CanPath COVID-19 Third Timepoint Questionnaire

This is the final questionnaire in the CanPath COVID-19 Antibody Study. Thank you for continuing to take part in this important study that will investigate how levels of antibodies to COVID-19 may change over time.

This questionnaire should be completed within **1 WEEK** of receiving it. You do not need to finish this questionnaire all at once. You may pause, save your progress and return to it at a later time.

Please enter a response to each question on the screen. If there are questions you do not feel comfortable answering, please select the "Prefer not to answer" option where applicable.

COVID-19 DIAGNOSES

DG01. Since September 1, 2021, do you think you currently have, or have had COVID-19?

1 Yes
0 No [SKIP TO DG05]
9 Don't know [Skip to DG05]

DG02. Why do you think you have, or have had, COVID-19?
Select all that apply:

1 Took a self-assessment online
2 Had symptoms that could be COVID-related (e.g., fever, sore throat, runny nose, difficulty breathing, etc.) that cannot be attributed to a previously existing condition
3 Nasal/throat/rapid test result
4 Told by a health care provider
5 Had contact with someone who tested positive for COVID-19
6 Other – please specify: _____

DG03. [if yes to Contact with someone who tested positive for COVID-19] On which date did you have first contact with this person after they were diagnosed with COVID-19?
If you don't remember exactly when, please choose an approximate date.

DD/MM/YYYY (date calendar – participant chooses date)
Don't know

DG04. [if yes to Contact with someone who tested positive for COVID-19] Who was this person with COVID-19?

Spouse or partner
Family member living in the same place
Family member living in another place

Housemate
Friend
Work colleague
Other - please specify: _____

DG05.[KM1] **Since September 1, 2021, have you been tested for COVID-19 (including a rapid test, nasal swab and/or blood testing)?**
1 Yes
2 No – because I haven't experienced any symptoms [SKIP to SY01]
3 No – I have experienced one or more symptoms (for example, a cough, mild fever, muscle soreness, fatigue) but have not been tested [SKIP to SY01]
4 No – I have experienced symptoms but I do/did not meet the testing criteria in my province [SKIP to SY01]
8 – Prefer not to answer

DG06. [if YES] How many times have you been tested? For serology/antibody testing please do not include the test you will be doing as part of this study.
A maximum of 8 tests can be reported. Please report all positive tests. Report test results from oldest to most recent.
1
2
3
4
5
6
7
8

DG07. For your first test, what was the type of test?
Rapid test (a rapid antigen test with results in 15-20 minutes)
Viral test (a nasal or throat swab for current infection)
Anitbody/serology test (blood test for past infection)

DG08. What was the date of your first test?
If you don't remember exactly when, please choose an approximate date.
DD/MM/YYYY
Don't know

DG09. What was the result of your first test?
Negative
Postive
Don't know

DG07 – DG09 will be repeated up to 8 times depending on the number of tests reported in DG06.

COVID-19 - CARE/HOSPITAL RELATED INFORMATION

The following questions are presented to participants with a positive test result for COVID-19.

CH01. Since September 1, 2021, were you hospitalized because of COVID-19?
1 Yes
0 No [SKIP to SY01]

CH02. [IF YES] What date did you get admitted to the hospital?
DD-MM-YYYY
9 Don't know

CH03. [IF YES] How many days were you in the hospital?
Note: to register your answers after you've typed them, simply click somewhere else on the page.
Number of days: _____
9 Don't know

CH04. [IF YES] Were you admitted to an intensive care unit?
1 Yes
0 No
9 Don't know

CH05. [IF CH04=YES] How long did you stay in the intensive care unit?
Note: If you don't remember the exact duration, please provide the best estimate that you can. This response must be less than or equal to the number of days spent in the hospital. Respond to all questions on this page before clicking 'Next Page'.
Number of days: _____
Don't know

CH06. Did you continue to experience COVID-19 symptoms or complications related to hospitalization after you were discharged?
1 Yes
0 No
9 Don't know

COVID-19 SYMPTOMS

We are interested in whether you've experienced flu-like and other symptoms, which may be related to COVID-19. For these next questions, please consider any symptoms which ***are not due to other health issues*** *you might usually experience/expect, such as seasonal allergies, existing medical conditions, etc.*

SY01. Since September 1, 2021, have you experienced any of the following symptoms? Please do not include symptoms related to factors you might usually experience/expect, such as seasonal allergies, asthma, COPD, or other existing medical conditions.

- Fever ≥38°C
- Dry Cough
- Wet cough (a cough that produces mucus)
- Runny nose
- Sinus pain
- Ear pain
- Sore throat
- Hoarseness
- Shortness of breath or difficulty breathing
- Headache
- Fatigue
- General muscle and/or joint aches and pains
- Chills or shivering
- Loss of taste
- Loss of sense of smell
- Diarrhea
- Loss of appetite
- Nausea
- Vomiting
- Wheezing
- Chest pain
- Confusion
- Dizziness
- Abdominal Pain
- Other respiratory symptoms

1 Yes
0 No [SKIP TO RF01]

SY02. Please indicate which symptoms you've experienced and the severity.
Please be sure to respond to all symptoms.

	0 No	1 Mild	3 Severe
Fever ≥38°C			
Dry Cough			
Wet cough (Cough that produces mucus)			
Runny nose			
Sinus pain			
Ear pain			
Sore throat			
Hoarseness			
Shortness of breath or difficulty breathing			
Headache			
Fatigue			
General muscle and/or joint aches and pains			
Chills or shivering			
Loss of taste			
Loss of sense of smell			
Diarrhea			
Loss of appetite			
Nausea			
Vomiting			
Wheezing			
Chest pain			
Confusion			
Dizziness			
Abdominal pain			
Other respiratory symptoms			

SY03. Did you experience any other symptoms?
1 Yes – please specify:_____
0 No other symptoms

SY04. [IF YES] How severe were these other symptoms?
Mild
Severe
Don't know

SY05. [IF YES TO ANY SYMPTOMS] When did you *first* experience these symptoms?
If you don't remember the exact date, please provide the best estimate that you can.
Value (DD-MM-YYYY)
Don't know

SY06. [IF YES TO ANY SYMPTOMS] When did you experience the most *recent* symptoms?
Note: The date entered must be later than, or the same as, the date you first experienced symptoms. Respond to all questions on this page before clicking 'Next Page'.
Value (DD-MM-YYYY)
Don't know

SY07. [IF YES TO ANY SYMPTOMS] While you were experiencing COVID-19 related symptoms, did you have close contact with any of the following people? Close contact means physical contact such as hugging, kissing, shaking hands, etc.
Please be sure to respond to all the questions. Select 'No' for a question if it doesn't apply to you, or 'Don't know' if you are not sure.

	Yes	No	Don't know
Spouse or partner			
Family members living in the same place			
Family members living in another place			
Housemates			
Friends			
Work colleagues			

SY08. [IF YES] Has any of those person(s) developed COVID-related symptoms?
Yes
No
Don't know

SY09. [IF YES] For those person(s) that developed COVID-related symptoms, which category/categories did they belong to and how many individuals were affected?
Select all that apply. Note: Values between 1-30 accepted. Please use numbers only. Avoid special characters such as "/".
Spouse or partner
Family members living in the same place - number of individuals:_____
Family members living in another place - number of individuals:_____
Housemates - number of individuals: _____
Friends - number of individuals:_____
Work colleagues - number of individuals:_____

SY10. [IF YES TO ANY SYMPTOMS] Do you continue to experience COVID-19 symptoms or complications?
1 Yes
0 No
9 Don't know

LONG COVID[KM2]

The previous questions asked you about a COVID-19 infection and symptoms since September 1, 2021. However, there is increasing evidence that some people who have had COVID-19 continue to experience lasting effects, sometimes called 'Long COVID' or 'Post COVID-19 Syndrome'. The following questions aim to capture longer lasting symptoms and impacts.

LC01. Have you ever had a COVID-19 infection?
Yes [Go to LC02]
No [Go to RF01]
Prefer not to answer [Go to RF01]

LC02. [IF YES TO LC01] When did you have COVID-19 (i.e., the active infection)? If you have had COVID-19 more than once, please focus your answers on the longest episode of illness you have experienced.
3 months ago or less
Between 3 and 6 months ago
Between 6 and 9 months ago
Between 9 and 12 months ago
More than 12 months (1 year) ago
Don't know

LC03. How long have you had / did you have COVID-19 symptoms overall? Please include time spent with mild symptoms and the time in between symptoms if these have been coming and going. If you have had COVID-19

more than once, please choose the duration for the same (longest) episode of illness you described in the previous question.
Less than 2 weeks [Go to LC07]
2-3 weeks [Go to LC07]
4-12 weeks [Go to LC04]
More than 12 weeks [Go to LC04]
Prefer not to answer [Go to LC07]

LC04. [IF 4-12 weeks or More than 12 weeks selected in LC03] Which of the following symptoms have you experienced for more than 1 month after infection? Please only consider symptoms that are not explained by another reason, and select all that apply.

	No	Yes – Mild	Yes – Severe
Headache			
Chronic Fatigue			
Shortness of breath or difficulty breathing			
Persistent cough			
Muscle aches/pains or weakness			
Loss of smell or taste			
Memory problems (e.g. brain fog, difficulty concentrating)			
Mental health concerns (e.g. anxiety, depression)			
Difficulty sleeping			
Heart problems (e.g. chest pain, fast heartbeat)			
Gastrointestinal upset (e.g. nausea, diarrhea)			

LC05. Are there any other symptoms that you have continued to experience for more than 1 month after the infection?
Yes – please specify:_____
No other symptoms

LC06. [IF YES] How severe have these symptoms been?
Mild
Severe
Don't know

LC07. [IF YES in LC01]. Please select the best option for how much you feel fully recovered from COVID-19:

Strongly disagree (i.e., still experiencing significant symptoms/effects)
Disagree
Neither disagree nor agree (i.e., mostly recovered but still experiencing some symptoms/effects)
Agree
Strongly Agree (i.e., fully recovered and not experiencing any symptoms/ effects)

LC08. [If YES in LC01] Please assess the impact of your COVID-19 infection on your:

	No impact	Mild impact	Moderate impact	Severe impact	Extreme impact	Not applicable
Personal activities (e.g., grocery shopping, gardening)						
Family life						
Professional life						
Social life						
Morale/mood						
Relationship with caregivers						

RISK FACTORS

RF01. At the present time, are you smoking cigarettes daily, occasionally, or not at all?

1 Daily (At least one cigarette every day for the past 30 days)
2 Occasionally (At least one cigarette in the past 30 days, but not every day)
3 Not at all (You did not smoke at all in the past 30 days)

RF02. At the present time, are you using electronic cigarettes, also known as an e-cigarettes?

Vaping products have many names, such as: e-cigarettes, vape pens, vapes, mods, tanks, and e-hookahs. They may also be known by various brand names.

1 Daily (At least one e-cigarette every day for the past 30 days)
2 Occasionally (At least one e-cigarette in the past 30 days, but not every day)
3 Not at all (You did not use e-cigarettes at all in the past 30 days)

RF03. At the present time, are you using cannabis?

1 Daily (At least once every day for the past 30 days)
2 Occasionally (At least once in the past 30 days, but not every day)
3 Not at all (You did not use cannabis at all in the past 30 days)
4 I have never used cannabis
8 Prefer not to answer

RF04. [if daily or occasionally] Which of the following methods to consume cannabis do you use most often?

1 Smoked
2 Vaporized
3 Consumed in food or drink
4 Other
8 Prefer not to answer
9 Don't know

RF05. At the present time, how often do you currently drink alcohol?

7 6 to 7 times a week
6 4 to 5 times a week
5 2 to 3 times a week
4 Once a week
3 2 to 3 times a month
2 About once a month
1 Less than once a month
0 Never
9 Don't know

MEDICAL CONDITIONS[KM3]

COVID-19 is a new disease and evidence of risk factors continues to evolve. People who have pre-existing medical conditions, or who have compromised immune systems may be at higher risk of serious illness, similar to what is seen with other respiratory illnesses, such as influenza.

MC01. Since March 2021 has a doctor told you that you have a cancer or a malignancy of any kind?

|_| Yes
|_| No → Skip to MC04
|_| Don't know → Skip to MC04

MC02. [If MC01 = Yes] What type of cancer?
Select all that apply:

|_| Bladder
|_| Brain
|_| Breast
|_| Cervix
|_| Colon
|_| Esophagus
|_| Kidney
|_| Larynx
|_| Leukemia
|_| Liver
|_| Lung and bronchus
|_| Lymphoma (Hodgkin Lymphoma)
|_| Lymphoma (non-Hodgkin Lymphoma)
|_| Mouth, tongue, and throat
|_| Multiple myeloma
|_| Ovary
|_| Pancreatic
|_| Prostate
|_| Rectum
|_| Skin (Melanoma)
|_| Skin (Non-Melanoma)
|_| Small intestine
|_| Stomach
|_| Testicle
|_| Thyroid
|_| Uterus
|_| Other – please specify:_____

MC03. [If MC01 = Yes] Are you currently undergoing treatment for the cancer or malignancies specified?

|_| Yes

|_| No
|_| Don’t know

MC04. Since March 2021, has a doctor told you that you have any of the following conditions?

- Diabetes
- Heart and circulatory conditions
- Respiratory system conditions
- Gastrointestinal conditions
- Liver or pancreas conditions
- Renal disease/kidney failure conditions
- Mental health conditions
- Neurological conditions
- Bone and joint conditions
- Skin conditions
- Immune system conditions
- Other condition(s)

|_| Yes
|_| No → Skip to MC07

MC05. [If MC04=Yes] Which of the following health conditions were you diagnosed with?
Select all that apply:
|_| Diabetes
|_| Heart and circulatory conditions
|_| Respiratory system conditions
|_| Gastrointestinal conditions
|_| Liver or pancreas conditions
|_| Renal disease/kidney failure conditions
|_| Mental health conditions
|_| Neurological conditions
|_| Bone and joint conditions
|_| Skin conditions
|_| Immune system conditions
|_| Other condition(s) – please specify:_____

MC06.

[If Selected in MC05] **Which type of diabetes were you diagnosed with?**	|_| Type 1 diabetes |_| Type 2 diabetes |_| Gestational diabetes only

[If Selected in MC05] **Which type of heart and circulatory conditions were you diagnosed with?** ***Select all that apply:***	|_| High blood pressure (hypertension, not including during pregnancy) |_| High cholesterol |_| Heart attack (myocardial infarction) |_| Heart failure |_| Atherosclerosis / Coronary heart disease (including angioplasty or stents) |_| Atrial fibrillation |_| Arrhythmia |_| Angina |_| Heart murmur |_| Valvular heart disease (e.g., aortic stenosis, mitral valve prolapse)
[If Selected in MC05] **Which type of respiratory system conditions were you diagnosed with?** ***Select all that apply:***	|_| Asthma |_| Chronic obstructive pulmonary disease (COPD) |_| Interstitial lung disease (lung tissue scarring resulting from other health conditions or exposures) |_| Chronic bronchitis |_| Cystic fibrosis |_| Emphysema |_| Sleep apnea
[If Selected in MC05] **Which type of gastrointestinal conditions were you diagnosed with?** ***Select all that apply:***	|_| Crohn's disease |_| Ulcerative colitis |_| Irritable bowel syndrome |_| Celiac disease |_| Stomach ulcers |_| Persistent acid reflux/Gastroesophageal reflux disease (GERD)
[If Selected in MC05] **Which type of liver or pancreas conditions were you diagnosed with?** ***Select all that apply:***	|_| Liver cirrhosis |_| Chronic hepatitis |_| Fatty liver (NAFLD- non-alcoholic fatty liver disease / NASH – nonalcoholic steatohepatitis) |_| Gallstones
[If Selected in MC05] **Which type of renal disease/kidney failure conditions were you diagnosed with?** ***Select all that apply:***	|_| Acute renal failure |_| Chronic renal failure |_| Kidney stones

[If Selected in MC05] **Which type of mental health conditions were you diagnosed with?** ***Select all that apply:***	|_| Major depression |_| Minor depression |_| Bipolar disorder |_| Post-traumatic stress disorder |_| Schizophrenia or Schizoaffective disorder |_| Obsessive compulsive disorder |_| Anxiety disorder |_| Eating disorder |_| Addiction disorder (e.g., alcohol, drug or gambling dependence)
[If Selected in MC05] **Which type of neurological conditions were you diagnosed with?** ***Select all that apply:***	|_| Thrombotic stroke |_| Hemorrhagic stroke |_| Multiple sclerosis |_| Migraines
[If Selected in MC05] **Which type of bone and joint conditions were you diagnosed with?** ***Select all that apply:***	|_| Arthritis **[If Arthritis Selected]** **Which type(s) of arthritis was it?** ***Select all that apply:*** |_| Rheumatoid arthritis |_| Osteoarthritis |_| Other - please specify: _____ |_| Don't know |_| Lupus |_| Fibromyalgia |_| Osteoporosis
[If Selected in MC05] **Which type of skin conditions were you diagnosed with?** ***Select all that apply:***	|_| Eczema |_| Rosacea |_| Psoriasis |_| Scleroderma
[If Selected in MC05] **Which type of immune system conditions were you diagnosed with?** ***Select all that apply:***	|_| HIV |_| A weakened or compromised immune system (such as Severe Combined Immunodeficiency) |_| Hashimoto's thyroiditis, Sjögren's syndrome, or Ankylosing spondylitis

MC07. Since March 2021, access to health services may have changed. Have you experienced any of the following changes related to your healthcare?
Select all that apply:
|_| Surgery cancelled or deferred → Skip to PI01
|_| Medical procedure (e.g., diagnostic or screening) cancelled or deferred → Skip to PI01
|_| Treatment cancelled or deferred → Skip to PI01

|_| Other health-related appointment cancelled or deferred (e.g., dental, vision, etc.) → Skip to PI01
|_| Use of virtual appointments with health care provider → Skip to PI01
|_| Delayed seeing a healthcare professional about an existing problem or concern
|_| Delayed seeing a healthcare professional about a new problem or concern
|_| Delayed routine healthcare service or visit (e.g., procedure, treatment or lab test)
|_| Regular lab tests cancelled or deferred → Skip to PI01
|_| Medication shortage → Skip to PI01
|_| Other – please specify:_____ → Skip to PI01
|_| None or not applicable → Skip to PI01

MC08 [If MC07 = Any of the Delayed responses] If you delayed pursuing a health service or treatment, what were the reasons?
Select all that apply:
|_| I was not comfortable seeking health services
|_| Regular health service provider was not accepting appointments
|_| I wanted to ensure the health system was available to others who may need it
|_| I lost my health benefits (e.g., my hours were reduced and/or I was laid off)
|_| I could not afford to access the services
|_| Other – please specify:_____

MC09. Are you currently taking, or have you taken in the past 12 months, an immunosuppressive or immunomodulatory medication (e.g., corticosteroids; disease-modifying anti-rheumetic drugs such as adalimumab, azathioprine, ciclosporin, etanercept, infliximab, methotrexate, rituximab, sulfasalazine, tocilizumab; anti-cytokine antibodies; interferons)?
| | No
| | Yes – currently taking each day
| | Yes – taken within the last few months (during the COVID-19 pandemic) but not every day[KM4]
| | Taken before March 2021 [KM5]but not currently
| | Don't know

MENTAL & EMOTIONAL IMPACTS

The following questions ask how you have been feeling since September 2021. ***Please note that a mental health professional will not follow-up with you if your responses to these questions suggest you are in distress.*** *If you are experiencing stress or anxiety and would like to access support, please reach out to mental health services available in your area.*

PI01. Since September 1, 2021, how often have you been bothered by the following problems?

	0 Not at all	1 Several Days	2 More than half of the days	3 Nearly every day

Feeling nervous, anxious, or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it's hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

PI02. [IF YES TO ANY ABOVE] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 Not difficult at all
1 Somewhat difficult
2 Very difficult
3 Extremely difficult

PI03. Since September 1, 2021, how often have you been bothered by the following problems?

	0 Not at all	**1 Several Days**	**2 More than half of the days**	**3 Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have				

noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				

PI04. [IF YES TO ANY ABOVE] If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
0 Not difficult at all
1 Somewhat difficult
2 Very difficult
3 Extremely difficult

PI05[KM6]**. Since March 2021, have you accessed mental health services?**
Select all that apply:
|_| No – I did not need it → Skip to VC01
|_| No – I was not comfortable seeking mental health support → Skip to VC01
|_| No – My regular mental health professional was not accepting appointments→ Skip to VC01
|_| No – I could not find a new mental health professional that was accepting clients → Skip to VC01
|_| No – I lost my health benefits (e.g., my hours were reduced and/or I was laid off) → Skip to VC01
|_| No – I could not afford to access mental health services → Skip to VC01
|_| Yes – Using resources that I already had in place
|_| Yes – I have initiated new use of services
|_| Other – Please specify:_____ → Skip to VC01
|_| Prefer not to answer → Skip to VC01
|_| Don't know → Skip to VC01

PI06. [If PI05 = Yes] Did you access mental health services for any of the following conditions?
Select all that apply:
|_| Anxiety
|_| Depression
|_| Stress
|_| Other – please specify:_____
|_| Prefer not to answer
|_| Don't know

VACCINES & SIDE EFFECTS

VC01. Have you received a vaccine against COVID-19?
Yes

No (skip to VC13)

[IF YES to VC01]

VC02. How many vaccine doses against COVID-19 have you received?	**VC03. Which vaccine(s) did you receive as your (first, second, third, fourth) dose?**	**VC04. When did you receive the first/ second/ third/ fourth COVID-19 dose?** *If you don't remember the exact date, please choose an approximate date.*	**VC05. In what setting did you receive the vaccine?**
1 2 3 4	Pfizer and BioNTech (Comirnaty) mRNA vaccine Moderna (Spikevax) mRNA vaccine AstraZeneca Oxford / Covishield (Vaxzevria) vaccine Janssen (Johnson & Johnson) vaccine Other - please specify (Open Text) Don't know [Skip to VC06]	DD/MM/YYYY	Hospital Public health clinic Pharmacy Nursing station Physician office Long-term care home Workplace clinic Other – please specify (open text)

Repeat VC03 – VC05 as many times as indicated in VC02.

VC06. [IF YES to VC01] Did you experience any side-effects (within the first few days) after receiving any dose of the COVID-19 vaccine?
Yes
No (SKIP to VC14)
Prefer not to answer

[IF YES to VC06] VC07. Did you experience the following side-effects from your first/ second/ third/ fourth dose?
Please be sure to respond to all symptoms.

	No	Mild	Moderate	Severe	Prefer not to answer

Fatigue					
Headache					
Fever >38°C					
Chills or shivering					
Muscle aches/pains					
Sore throat					
Difficulty swallowing					
Shortness of breath or difficulty breathing					
Wheezing					
Chest pain					
Fast heartbeat					
Blurry vision					
Dizziness or light-headed					
Abdominal pain					
Nausea					
Vomiting					
Diarrhea					
Rash, redness, or hives on other places on your body (other than the arm where you had the needle)					
Swelling of other places on your body (other than the arm where you had the needle)					
Numbness (in places of your body other than the arm where you had the needle)					
Prickling or tingling (in places of your body other than the arm where you had the needle)					

Repeat VC07 for as many vaccine doses as the participant has received.

VC08. [IF YES to VC06] Did you experience any other side-effects not mentioned above?
Yes – please specify (open text)
No

VC09. Which dose did you experience these other side effects? Select all that apply.
|_| First dose
|_| Second dose
|_| Third dose
|_| Fourth dose

VC10. [If Mild/Moderate/Severe to any symptoms in VC06 or YES to VC08] Did you contact a healthcare provider about these symptoms?
Yes
No
Prefer not to answer

VC11. [If Mild/Moderate/Severe to any symptoms in VC06 or YES to VC08] Did you require hospitalization for these symptoms?
Yes
No
Prefer not to answer

VC12. [If Mild/Moderate/Severe to any symptoms in VC06 or YES to VC08] How long did these symptoms last?
Note: to register your answers after you've typed them, simply click somewhere else on the page.
___ days
Don't know

VC13. [Skip if VC01 = YES] If you have not received a vaccine yet, how likely are you to get one in the future? [KM7]
Very likely
Somewhat likely
Somewhat unlikely
Very unlikely
Prefer not to answer

VC14. What are the main concerns you have around getting the vaccine? (Select all that apply. If you have already received the vaccine, what were your main concerns?)

No concerns about getting the vaccine
I am worried about unknown future effects of the vaccine
I am worried about side-effects
Vaccines are limited and other people need it more than me
I don't trust vaccines
I previously tested positive for COVID-19 and so should have protection
The chances of me becoming seriously unwell from COVID-19 are low
The chances of me catching COVID-19 are low
The impact of COVID-19 is being greatly exaggerated
I don't think it would be effective at preventing me from catching COVID-19
I have a condition which would make it unsafe for me
Herd immunity will protect me even if I don't have the vaccine
It's not offered at a location that is easy for me to get to
Other – please specify (open text)

OTHER

OT01.[KM8] **Since March 2021**[KM9]**, have you worked or volunteered in any of the following positions**:

- Hospital or healthcare facility worker (including long term care facilities)
- Health professional in community-based settings (not in hospital)
- Social and community service worker (outside of hospital or healthcare settings; includes services provided in private homes)
- First responder
- Correctional officer
- Other services requiring entry into private homes
- Teacher, school staff and childcare
- Transit/Shuttle driver
- Passenger and delivery drivers (e.g., Taxi, Uber, Limousine driver; food delivery such as Uber Eats, Skip The Dishes, restaurant deliveries, etc.; package deliveries)
- Food service industry worker
- Grocery Store Worker
- Casino Worker
- Retail Store Worker
- Hairdresser/Barber
- Aesthetician
- Airline or Airport employee
- Factory Worker
- Farm Worker
- Oil and gas extraction staff

|_| Yes
|_| No → Skip to OT03
|_| Prefer not to answer → Skip to OT03

OT02. [If OT01 = Yes] Which positions have you worked or volunteered in since March 2020?
Select all that apply:
|_| Hospital or healthcare facility worker (including long term care facilities)
|_| Health professional in community-based settings (not in hospital)
|_| Social and community service worker (outside of hospital or healthcare settings; includes services provided in private homes)
|_| First responder
|_| Correctional officer
|_| Other services requiring entry into private homes
|_| Teacher, school staff and childcare
|_| Transit/Shuttle driver
|_| Passenger and delivery drivers (e.g., Taxi, Uber, Limousine driver; food delivery such as Uber Eats, Skip The Dishes, restaurant deliveries, etc.; package deliveries)
|_| Food service industry worker
|_| Grocery Store Worker
|_| Casino Worker
|_| Retail Store Worker
|_| Hairdresser/Barber
|_| Aesthetician
|_| Airline or Airport employee
|_| Factory Worker
|_| Farm Worker
|_| Oil and gas extraction staff

OT03.[KM10] **Prior to the pandemic, what was your approximate total household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.**
|_| Less than $10,000
|_| $10,000 - $24,999
|_| $25,000 - $49,999
|_| $50,000 - $74,999
|_| $75,000 - $99,999
|_| $100,000 - $149,999
|_| $150,000 - $199,999
|_| $200,000 or more
|_| Prefer not to answer
|_| Don’t know

OT04. Has your monthly household income been changed because of the COVID-19 pandemic?
|_| Substantially decreased
|_| Somewhat decreased
|_| No change
|_| Somewhat increased

|_| Substantially increased

OT05. Have your household savings been changed because of the COVID-19 pandemic?
|_| Substantially decreased
|_| Somewhat decreased
|_| No change
|_| Somewhat increased
|_| Substantially increased

OT06. Which of the following best describes the impact of COVID-19 on your ability to meet financial obligations or essential needs, such as rent or mortgage payments, utilities and groceries?
|_| Major impact
|_| Moderate impact
|_| Minor impact
|_| No impact
|_| Too soon to tell

ANTHROPOMETRICS [KM11]

Not only does our height and weight change as we age, the COVID-19 pandemic may have caused changes in your eating and activity habits. Please tell us your current height and weight, following the measurement instructions provided.

AM01. How tall are you?
Please answer the question using feet and inches or centimeters. If entering your height in feet and inches, please include a number for BOTH feet and inches.
Feet_____ & Inches _____
Centimetres_____
|_| Prefer not to answer
|_| Don't know

AM02. How much do you weigh?
- ***Adjust your scale to zero;***
- ***Weigh yourself with your clothes off, or wear light clothing. Remember to remove your shoes.***
- ***Step on the scale. Make sure both feet are fully on the scale.***
- ***Record your weight in pounds or kilograms.***
- ***If you don't have a scale, please estimate your current weight.***

Pounds_____
Kilograms_____
|_| Prefer not to answer
|_| Don't know

BLOOD SPOT SAMPLE

The following questions may help interpret results from the analysis of the blood spot sample you will provide.

BL01. Have you received a blood transfusion in the past 2 months?

1 Yes
0 No

BL02. Have you received chemotherapy in the past 3 months?

1 Yes
0 No

BL03. Have you received radiotherapy treatment in the last 3 months?

1 Yes
0 No

Click *Finish* to submit this questionnaire.